Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Ryan Potter, MD 5734 Spohn Dr. Corpus Christi, TX 78414	MFDR Tracking #: M4-07-0629-01 Inj[redacted]
Respondent Name and Box #: Texas Mutual Insurance Co Rep. Box #: 54	E Insu

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCU[redacted]

Requestor's Position Summary: "Preauthorization was obtained prior to services being rendered, according to TWCC Fast Facts, if pre-approval was obtained for a compensable injury, approval guarantees payment."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - $375.45
3. CMS 1500s
4. EOBs
5. Letter of Preauthorization Dated 04/20/06 #1677115

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "Texas Mutual denied the Lumbar Epidural Steroid Injection billed under code 62311 for date of service 06/08/06 for lack of preauthorization. The requestor did not seek preauthorization or obtain approval required as per DWC Rule 134.600."

Principal Documentation:

1. Response to DWC 60

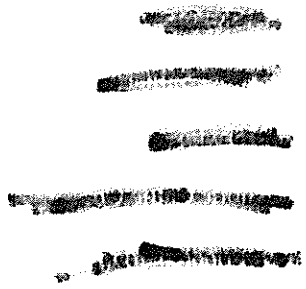
PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes	Denial Codes	Part V Reference	Amount Ordered
06/08/06	62311	62, 930, 18, 224, 877, W4	1, 2	$0.00
06/08/06	76005-26	62, 930, 18, 224, 877, W4	1, 2	$0.00
Total Due:				$0.00

Sent
DEC 2007
TEXAS DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.



1. These services were denied by the Respondent with reason code

- 62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization
- 930 – Pre-Authorization required, reimbursement denied
- 18 – Duplicate Claim/Service" and "224 – Duplicate Charge
- 877 – Bill previously processed. Original audit decision remains the same. – Please resubmit as an appeal per Rule 133.304(K)
- 224 – Duplicate charge
- W4 – No additional reimbursement allowed after review of appeal/reconsideration

2. To address denials of "62" and "930", a letter of Preauthorization #1677115 was provided by Requestor showing authorized procedures (CPT codes 62350, 62362, 62368, 95991, 76003, and 00630) for performance at SPINECARE LLC. CPT codes 62311 and 76005-26 as documented and billed are not the same as the authorized services, therefore, reimbursement to Requestor is not recommended per Rule 134.600.
3. Denials based on duplication of services using codes "18", "877", "224", and "W4" are from request for reconsideration audit on 09/08/06 as original audit was done 07/12/06, therefore are correctly denied.

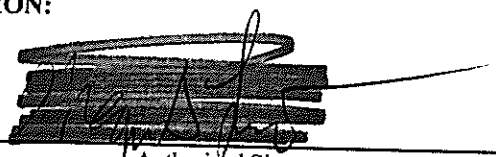
PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Section 134.1, Section 134.202, and Section 134.600.
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:



Authorized Signature

[redacted]

Medical Fee Dispute Resolution Officer

11/19/07

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.